

Insight Sound

WINTER ISSUE +
2018 +
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MSK



MUSCULOSKELETAL

• AWARENESS MONTH •

 **sound**
RADIOLOGY

DIGITAL MRI | LOW-DOSE CT SCAN | ULTRASOUND | XRAY

On the Political Front

On Tuesday 8th of May, we all received the Federal Budget for 2018-19. It didn't make great viewing for many, however I was very keen to see if there was any news for radiology in the next year's funds allocation.

As many of you are aware, Sound Radiology invested significantly in our MRI unit two years ago. We did so to be able to provide the community with the best MRI facility and one that would

help support those who fear having an MRI scan. We are pleased to say that our results have impressed many. We successfully perform non-sedated MRI scans for children (as young as 4) and patients with claustrophobia and our images have been published internationally. When we showcased our unit, people were in awe of how 'beautiful' the room was with its changing lights and video imagery. We really need to impress the Federal Government.

Currently Sound Radiology cannot access Medicare funding for our patients' scans.

A SNAPSHOT:

- Access to Medicare rebates for MRI is through a licence system
- Not all MRI studies attract a rebate from Medicare
- There have been no applications to apply for an MRI eligibility licence since 2012
- MRI systems that do have a licence may be more than 10 years old and are not in the best interest for patient diagnosis



In November last year I met with the Federal Health Minister, The Hon Greg Hunt. I was pleased to hear that he was absolutely amazed with our MRI unit

He heard about the cutting edge imaging we were performing on some of South Australia's most vulnerable patients. He is certainly open to funding solutions for greater Medicare access for MRI studies, but as we all know, it is difficult to find money in their budget.

Recently there has been a Senate enquiry regarding the accessibility of Diagnostic Imaging services for Australians and access to affordable MRI was top of the list. Sound Radiology works closely with the Department of Health and Ageing to help deliver these outcomes for our local community and we are hopeful that our collaboration will see us provide Medicare supported MRI scans in the near future.

For further information, please email info@soundradiology.com.au

Staff Profile



Peter

PETER ESSELBACH

Peter Esselbach is a musculoskeletal sonographer with 28 years in private practice radiology, working the last 3 years with Sound Radiology. He has also worked in cardiac, vascular and general sonography practices. Peter completed his Diploma in Interventional Ultrasound in 2017 and has a keen interest in going beyond the core diagnosis and looking into the contributing musculoskeletal dysfunctions.

Peter is also a musculoskeletal physiotherapist and exercise physiologist and has worked with the Adelaide Crows Football Club. With his background, Peter enjoys not only assisting in making the diagnosis, but in helping clients find the best pathway to recovery.

Peter is married with two girls and enjoys cycling, badminton, travelling and watching the Crows.

Health & Fitness

Monitoring Visceral Fat

The term visceral fat has become a common reference in the health landscape in recent years. But what is it and why is it so important?

Body fat or adipose tissue is generally categorised into two compartments; subcutaneous adipose tissue (SAT) and visceral adipose tissue (VAT). Subcutaneous adipose tissue is the fat tissue that lies immediately beneath the skin, whilst visceral adipose tissue is the fat tissue that surrounds and has the potential to infiltrate the internal organs of the upper abdomen. Once thought to cushion and protect the body, more recently its critical role in energy storage along with endocrinological signalling has been identified.

The central obesity epidemic is growing to alarming levels and recent investigations have demonstrated that this excessive visceral adiposity has a strong correlation with several

metabolic abnormalities (insulin resistance, impaired glucose and lipid metabolism). With an increased predisposition to cancers of the breast, colon and prostate, along with an increased cardiovascular risk profile, it is time to take our weight, but more importantly visceral fat accumulations, seriously.

DEXA is a whole-body imaging technique that allows the measurement of VAT deposits. It is fast, non-invasive and validated against the far more expensive and time-consuming alternatives. Thus, it is a great tool which can be utilised in several health-related scenarios around risk stratification and monitoring.



Expert Advice

A/Prof Nicole Williams explores how to increase early detection of developmental dysplasia of the hip (DDH), improving patient outcomes.

Developmental dysplasia of the hip (DDH) is a term used to describe a spectrum of hip problems in infants and children ranging from subtle instability to complete dislocation of the femoral head (ball) from the acetabulum (socket). Despite an ongoing clinical screening program, cases of late diagnosed DDH have increased in Australia in recent years. Early treatment of DDH is more effective, less invasive and has fewer complications, so what can be done to reduce late diagnosed DDH?

Prevention: Promote safe swaddling and baby carrying techniques.

DDH is most common in female breech babies and those with a family history but can occur in any baby and hip development can also be affected post-natally. To reduce the risk of DDH, parents should be educated about safe swaddling and baby carrying techniques. Lower limbs should only ever be loosely swaddled in young babies to allow hips to sit in their natural position, flexed and abducted (up and out). Baby-wearing keeping the legs in this same "up and out" position, sometimes called the "M" position is thought to be protective against DDH. For more information visit hipdysplasia.org.

Detection: A move from screening to surveillance.

Carefully performed clinical examinations of a child's hip from newborn to walking age are the best method for early detection of DDH. Newborn screening should be supplemented with regular DDH assessments which can be carried out by a range of suitable practitioners including CaFHS nurses, physiotherapists and GPs. Given the ongoing relationship between child and GP and regular appointments for immunisations and common childhood illness, GPs who see young children in their practice are well placed to identify any changes in the hip examination and provide preventative health advice.

What happens if your child is diagnosed with DDH?

If a diagnosis of DDH is suspected on clinical examination, your child's GP or paediatrician may recommend medical imaging to gain further information. Ultrasound is the method of choice until 4 months of age, between 4-6 months x-ray or ultrasound can be used and

A/Prof Nicole Williams

after 6 months x-ray is preferred. Your child may be referred to an Orthopaedic Surgeon and a brace, cast or surgery may be recommended.

Associate Professor Nicole Williams is an Orthopaedic Surgeon specialising in the management of infants, children and adolescents with orthopaedic conditions. She consults from Orthopaedic SA's new Parkside rooms, located next door to Sound Radiology at 257 Fullarton Rd.

If parents notice that their child has a waddle, limp, difference in leg length or a hip click, they should discuss this with their GP or Paediatrician.

Winter Recipe

RED CURRY PUMPKIN & YELLOW LENTIL SOUP

- + 2KG JAP PUMPKIN
- + 1.5KG BUTTERNUT PUMPKIN
- + 1 CUP RED LENTILS
- + 600ML COCONUT MILK

STEP 1

Cut pumpkin into large chunks place on baking tray. Combine all spices, red curry paste and oil (onions and garlic if using) and toss to coat. Place in hot oven for approximately 45 mins

STEP 2

Cover red lentils with water in a saucepan and bring to boil, then drain and rinse. Transfer roasted pumpkin and rinsed lentils to slow cooker or large saucepan and add approx 4 cups chicken stock or water.

- + 4 TBSP RED CURRY PASTE
- + 2 TSP ONION POWDER OR 2 FRESH ONIONS
- + 2 TSP GARLIC POWDER OR 4 FRESH GARLIC

STEP 3

Add half of coconut milk and bring to boil. Then simmer for 45 mins to 1hr, or cook on high for 4-6hrs in slow cooker.

STEP 4

Blitz until creamy and add the rest of coconut milk, stir to combine.

STEP 5

Heat through then serve with crusty bread.

SERVES 10-12 LARGE SERVES

- + SALT AND PEPPER TO TASTE
- + 4 CUPS CHICKEN STOCK OR WATER
- + OLIVE OIL TO COAT PUMPKIN PRIOR TO ROASTING



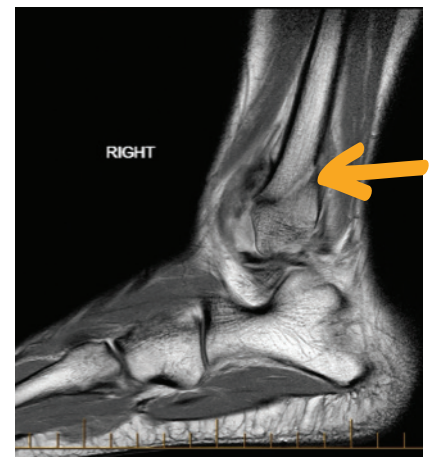
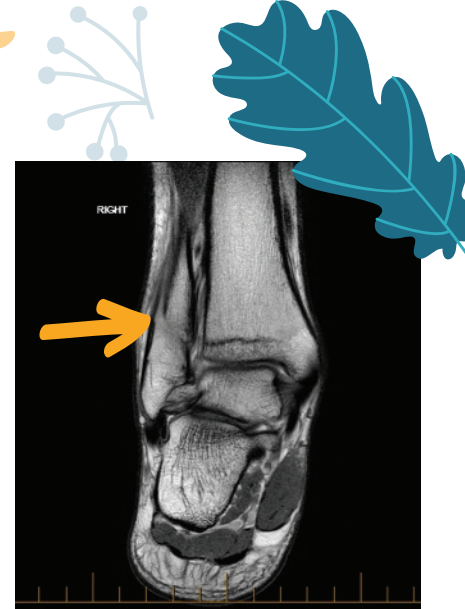
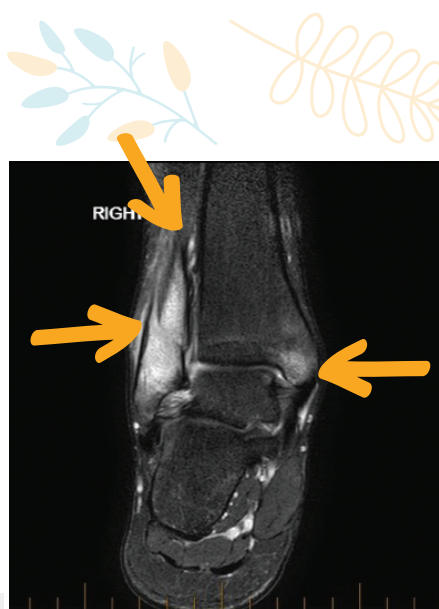
Case study

A 19-year-old male patient was referred by their Physiotherapist for an MRI of their right ankle. The patient injured their ankle 3 weeks prior during a football game with impact from behind and their foot in plantar flexion. The patient had no previous imaging until now but still had some pain, therefore the Physiotherapist queried an Anterior Inferior Tibiofibular ligament (AITFL) sprain.

The findings from the MRI proved markedly more significant than a ligament sprain.

THE FINDINGS:

- + Oblique fracture of the distal fibula with associated joint effusion
- + Bone bruising of the medial malleolus but no definite fracture seen
- + Disruption of the anterior and posterior inferior tibiofibular ligaments
- + Significant syndesmotic injury



The findings were discussed with the referring clinician following the scan, as the patient had intended on playing football the following day. Management advice from the Physiotherapist for the patient was strictly

non-weightbearing on the right ankle/foot with crutches and a moon boot to be utilised and the patient was referred for an Orthopaedic opinion.

This patient is returning for a follow up CT scan from the Orthoped to monitor the fracture in 2 weeks.

Services we provide

- + General xray
- + Fluoroscopy
- + Dental imaging
- + Low dose CT scanning
- + Digital MRI
- + Mammography

- + Ultrasound (including subspecialists in obstetrics, gynaecology, paediatric and sports medicine)
- + Bone densitometry
- + Body composition scanning



257 Fullarton Road
Parkside, SA 5063

8357 8855

f (08) 8357 2868

e info@soundradiology.com.au

www.soundradiology.com.au

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